Managing challenging behaviour in dementia

A person centred approach may reduce the use of physical and chemical restraints

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Challenging behaviour is a catch-all term that, in the context of dementia, includes one or combinations of shouting, wandering, biting, throwing objects, repetitive talking, destroying personal possessions and other objects, agitation and general anger, physical attacks on others, and waking others at night. In short, this term describes any behaviour by patients that is deemed to be dangerous to themselves, their fellow patients, and staff, or is considered antisocial within environments where those patients have to coexist with others on a long term basis.

The treatment of such behaviours has traditionally been led by institutional policies of control and containment, consisting of combinations of environmental, mechanical, or chemical restraint.[1] However, such approaches are increasingly being challenged both on ethical grounds and for their evidence base. Now a randomised controlled trial in this week's *BMJ* reports that a psychosocial intervention—education and support for nursing home staff to promote more person centred care—provides an effective alternative to neuroleptic drugs.[2]

What is the evidence for traditional approaches to managing challenging behaviour in dementia? Environmental restraint, considered by some to be a safety measure, means the containment of individuals within specific rooms or units by methods such as locking doors and generally policing the use of space. Such restraint emphasises the institutional nature of care settings and of patients' experiences of services, and current best practice aims to minimise its use. Mechanical restraints such as bed rails and belts are still routinely used to control nursing home residents who are cognitively impaired.[3] As with environmental restraint, nurses usually justify this on the grounds of patient safety, citing prevention of hip fractures from falls as well as the need to control disruptive behaviours.[3]

There is, however, little scientific evidence to suggest that mechanical restraints significantly reduce risk or harm; indeed, using fewer mechanical restraints may even reduce serious injuries in nursing home residents.[4] A substantial proportion of nursing home residents with dementia are given tranquillisers to subdue problem behaviours.[5] Again, there is only limited research evidence for the effectiveness of such chemical restraint,[6 7] and some say that it can be harmful.[8]

Are past and current justifications for many forms of restraint merely part of a humanistic rhetoric?[9] The more general ethical debate over recent years has often handled environmental, mechanical, and chemical restraints in unison.[10 11] In particular, ethicists have attacked the utilitarian argument of maximising the reduction of harm to the patient and those around them through restraint. Moreover, citing the principles of autonomy and beneficence, ethicists have challenged the argument that restricting autonomy through restraint is necessary to act beneficently.[12]

These wide ranging arguments against restraint are certainly convincing. But they will have little impact on practice unless clinicians explore viable alternatives to protect and care for their patients, such as research on psychosocial interventions and the intricacies of procedures and practices used in long term care.[2]

Indeed, if clinicians overcome the barriers associated with cognitive impairment, and if they decipher the subtle messages in their patients' actions, they will be able to realise that much challenging behaviour is not meaningless, unpredictable, and only manageable through restraint.[1] Moreover, the behaviours of staff, particularly the recognition and manipulation of trigger situations, may play a central role in the manifestation of challenging behaviours in patients.[7] Long term care needs a "back to basics" approach, focusing on core values and activities and on the proximities, interactions, and relationships between people. The hope is that, through this, a new culture of dementia care should focus on meeting individual patients' needs, rather than on restraint.[1]

Further clinical trials of psychological and psychosocial interventions to manage challenging behaviour in dementia are needed urgently.[7] Quantitative surveys and in depth qualitative research should also help in understanding important contexts, such as health systems and institutions and public perceptions and attitudes.

It will not be easy to engage staff in using non-pharmacological and non-physical methods and to overturn predominant cultures of practice. Knowledge translators, for example advanced practice nurses, will have a central role in creating consistency within and between clinical environments. Health services worldwide need to establish national guidelines and standards for all practices associated with challenging behaviour, including those of a psychological or psychosocial orientation.

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